**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

1. Client’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**First Name Middle Name Last Name**

2. Date of Birth: ­­­\_\_\_/ \_\_\_\_/\_\_\_

3. Date authorization initiated: \_\_\_\_/ \_\_\_\_/\_\_\_\_

4. Authorization initiated by:

Name (client, provider or other): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Information to be Released:

**Progress in treatment, Treatment Plan, Medication Issues, Health Issues, Safety Concerns, Treatment History and Diagnostic Information.**

\* ⁪Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for

Psychotherapy Notes, you must not use it as an authorization for any other type of protected health

information.)

\* ⁪Other (describe information in detail):

6. Purpose of Disclosure: The reason I am authorizing release is: **Coordination of Care and Treatment Planning.**

7. Person(s) Authorized to Make the Disclosure: **Joey Downey, LMFT @ 558 “B” Street, Santa Rosa, CA 95401**

8. Person(s) Authorized to Receive the Disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. This Authorization will expire on \_\_\_/ \_\_\_ / \_\_\_\_ or upon the happening of the following event:

**termination of treatment**

**Authorization and Signature:** I authorize the release of my confidential protected

health information, as described in my directions above. I understand that this authorization

is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is

to be made to conform to my directions. The information that is used and/or disclosed

pursuant to this authorization may be redisclosed by the recipient unless the recipient

is covered by state laws that limit the use and/or disclosure of my confidential

protected health information.

**Signature of the Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Personal Representative:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient if Personal Representative:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of signature:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**The following specifies your rights about this authorization under the Health Insurance Portability**

**and Accountability Act of 1996, as amended from time to time (“HIPAA”).**

1. Tell your counselor if you don’t understand this authorization, and the counselor will

explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to

the extent information has already been shared based on this authorization; or (b) this

authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel

this authorization, you must submit your request in writing to provider at the following address

(insert address of provider): **558 “B” Street, Santa Rosa, CA 95401**

3. You may refuse to sign this authorization. Your refusal to sign will not

affect your ability to obtain treatment or payment or your eligibility for benefits. If you

refuse to sign this authorization, and you are in a research-related treatment program or have

authorized your provider to disclose information about you to a third party, your provider has the

right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this

authorization, this office has no control over how it will be used by the recipient. You need to

be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed

authorization.

6. Special Instructions for completing this authorization for the use and

disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records

known as “Psychotherapy Notes.” All Psychotherapy Notes recorded on any medium (i.e., paper,

electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept

by the author and filed separate from the rest of the client’s medical records to maintain a higher

standard of protection. “Psychotherapy Notes” are defined under HIPAA as notes recorded by a

health care provider who is a mental health professional documenting or analyzing the

contents of conversation during a private counseling session or a group, joint or family counseling

session and that are separate from the rest of the individual’s medical records. Excluded from the

“Psychotherapy Notes” definition are the following: (a) medication prescription and monitoring, (b)

counseling session start and stop times, (c) the modalities and frequencies of treatment furnished,

(d) the results of clinical tests, and (e) any summary of: diagnosis, functional

status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release “Psychotherapy Notes” to a third party, the client who

is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for

the release of Psychotherapy Notes. Such authorization must be separate from an authorization to

release medical records.